Prescriber Criteria Form

Abiraterone 2026 PA Fax 661-A v2 010126.docx
Abirtega, Zytiga (abiraterone), Abiraterone
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Abiraterone.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of metastatic prostate cancer? [If yes, then skip to question 6.]	Yes	No
2	Does the patient have a diagnosis of non-metastatic (M0) prostate cancer that meets any of the following: A) node-positive (N1), B) high-risk, C) prostate-specific antigen (PSA) persistence/recurrence following radical prostatectomy? [If yes, then skip to question 6.]	Yes	No
3	Does the patient have a diagnosis of very-high-risk prostate cancer? [If yes, then skip to question 6.]	Yes	No
4	Does the patient have a diagnosis of salivary gland tumors? [If no, then no further questions.]	Yes	No
5	Is the requested drug being used for the treatment of recurrent androgen receptor positive disease? [If no, then no further questions.]	Yes	No
6	Will the requested drug be used in combination with a gonadotropin-releasing hormone (GnRH) analog OR after bilateral orchiectomy?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____